

In this second article, health economist **Dr Darrin Baines** sets out a likely future for pharmacy contractors

# Time for a radical change?

**F**aults in the initial design of the NHS are still causing problems in community pharmacy today. The original structure of the system has forced community pharmacists to provide a demand-led service, which does not take a population-focused perspective on patient care.

Attempts to modernise community pharmacy have often been based upon small, incremental changes in emphasis or activities.

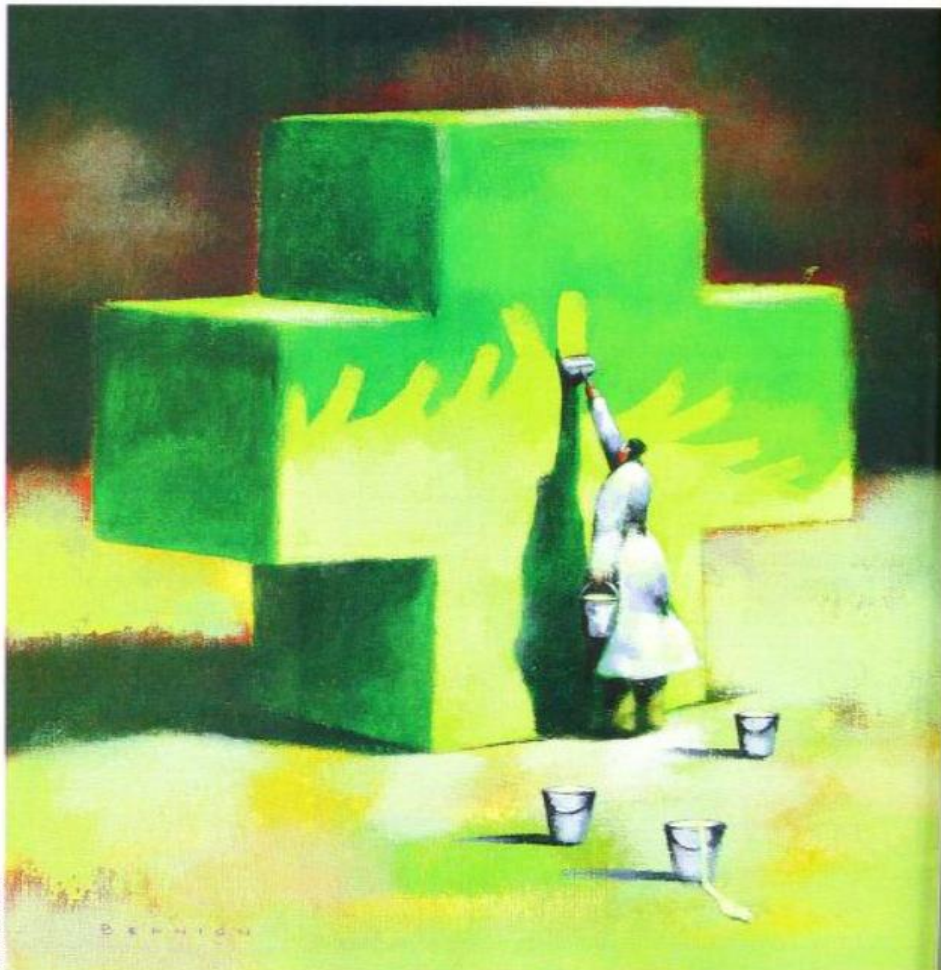
Attempts to improve the function of the system often focus on minor, solvable issues, rather than questioning its operation as a whole. For example, initiatives designed to make the profession more 'patient-focused', or to promote greater working with general practitioners, only achieve relatively small gains. Indeed, they often fail to produce the sustainable and radical change that the system requires.

## Working in isolation

Community pharmacy is immune to many of the pressures faced elsewhere within the NHS. Pharmacists do not have to plan and provide services for the whole of their local populations, and work within cash-limited service budgets. On the contrary, they simply have to meet the demands of individual patients, as they present themselves (or their scripts) at local chemist shops. As they are not involved in the rationing process, pharmacists do not have to take difficult decisions about how best to allocate scarce NHS resources.

The failure to take a population-centred approach or to become involved in the allocation of scarce resources, should not be seen as the fault of pharmacists, either as individuals or a professional group. The NHS was purposefully designed in a way that isolated pharmacists from general practitioners, their local populations and financial constraints.

Even when individual pharmacists want to take more responsibility, the system conspires against sustainable change. Indeed, the NHS is extremely territorial, and community pharmacists have been given few organisational or financial means of securing change.



## The second revolution

The current arrangements for community pharmacy were introduced at a time when there were relatively few pharmaceutical products and when the dispensing apothecary, chemist or druggist prepared the majority of drugs.

The introduction of the NHS coincided with a revolution in pharmaceutical technology, which led to the development of an international pharmaceutical industry. However, the architects of the NHS

did not envisage this revolution, with the result that they simply adopted the community pharmacy arrangements initiated under the National Insurance Scheme. Only by luck did these arrangements survive the rapid growth in prescribing volumes and costs that accompanied the first, major revolution in pharmaceutical technology.

The second, major revolution in pharmaceutical technology has just begun and will be based upon rapid developments in genomics and genetics. The former will lead to a

greater understanding of how the genetic constitution of a population is related to health and disease in that group. The latter will lead to a greater understanding of how the disease process operates within individuals and will stimulate the development of radically new genetic tests, diagnostic procedures and interventions.

The development of genomics and genetics will have two major impacts on community pharmacy. First, the notion of a local population will

*Continued on P22*

## Practice

→Continued from P20

greatly change. As a result, discussions about patient groups will not focus on their social and economic status, where they live, or the diseases that they have. Instead, patient groups will be defined in terms of their genetic make-up. In response, community pharmacy will have to provide individually tailored patient care.

Second, the notion of a patient as consumer, who requests medicines on an *ad hoc* basis, will eventually disappear. In the future, patients will be monitored throughout their lives, and genetically based interventions will be planned well in advance of symptoms appearing. Indeed, the idea that patients requested medicines on an *ad hoc* basis, without a full understanding of their conditions or the effectiveness of available treatments, will seem as laughable to future generations of pharmacists as quackery does to the profession today.

### Looking forward

For too long, community pharmacy has been focused on meeting the retail needs of individual consumers. In the future, responding to consumer demands (as we currently know it) will be the preserve of a small number of marketing-based, drug promotion and supply companies. These companies will operate niche pharmacy shops in financially viable communities, and will undertake direct-to-patient marketing and supply for those with chronic conditions, or those who desire life-style drugs.

As a result of these developments, patient-focused pharmacy will take on a completely new meaning and will be seen more as a marketing exercise than as true, community-based patient care.

In response to developments in product marketing and genetic technology, the traditional community pharmacist will disappear. Some in the profession will follow the lead of the apothecaries in the 1700s and develop a greater range of medical skills. Others will become more focused on marketing and direct sales activities and will supervise the dispensing of drugs by teams of less qualified assistants. The others, less organised members of the profession, will increasingly find their businesses financially unstable and will look to their political leaders for the protection of the status quo. Given the limits of NHS funding and changes in demand due to the introduction of genetic technology, over time their professional leaders will be less and less able to protect this group.



### Local solutions

If community pharmacy is to survive the genetics revolution, the system will have to change radically. Publicly funded pharmacists will have to leave the security of their community-based shops and base themselves around genetically defined patient groups.

Pharmacists who do not respond to advances in pharmaceutical technology may find themselves either working as part of a consumer focused, marketing organisation, or increasingly unable to make locality-based, community pharmacy a financially viable option.

In response to the advancement of new genetic technologies, both the profession and the Government will have to concede changes in the structure of community pharmacy. Out will go one national contract for all pharmacists, locality-based shops and fees for dispensing. In will come locally negotiated contracts for providing agreed forms of pharmaceutical care for particular patient groups.

These contracts will be accompanied by a budget allocation for meeting agreed performance indicators (such as the percentage of patients genetically tested, diagnosed and treated). The contracts will not, however, state that the current structure of community pharmacy must be preserved.

As a part of the move to local pharmacy contracts, patients will no longer be registered with their practitioners, but with organisations that provide all aspects of community based health services. Pharmacists will work for these organisations and supply their contracted activities in patient homes, drop-in centres, or

other places in which target individuals can easily be reached. Patients will not receive scripts or be free to choose whether to take their medicines, without prior consultations with their physicians and pharmacists. Instead, they will be placed on long-term care plans, which will involve the negotiation and monitoring of their compliance. The future, therefore, will involve the development of long-term relationships between practitioners, patients and a new type of community pharmacist.

### All change?

The sustainability of community pharmacy as we currently know it is reaching an end. The focus on consumer-based dispensing and one contract for all pharmacists must go. In its place, genetic technology will force pharmacists to leave their shops and to work with organisations that provide care in any setting that ensures that their centrally set targets for patient outcomes are met. In response, individual pharmacists will have to decide whether publicly funded community pharmacy is the place in which they still wish to work.

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